REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

292

REVIEW OF THE DISCIPLINARY FUNCTIONS OF THE DEPARTMENT OF INSURANCE

APRIL 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

MIKE CULLEN
CHAIRMAN

April 19, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's review of the disciplinary functions of the State Department of Insurance.

Its Table of Contents tells the story. "...Favoritism... Insufficient investigation of illegal kickbacks...Failure to expeditiously revoke licenses...Inadequate management of investigations...Inadequate investigation of business practices ...Ineffective organization...Inadequate security."

The principal objective of the Department of Insurance is the protection of insurance policyholders in the State. The Department enjoys a staff of 372 and an annual budget of $6.6 million. After reading the report of the Auditor General, one must wonder, "Who is watching the store?"

By copy of this letter, the Department is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department.

The auditors are David B. Tacy and J. Peter Bouvier.

Respectfully submitted,

MIKE CULLEN
Chairman

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SUMMARY

The Department of Insurance's organization and procedures for investigating and resolving public complaints against insurance companies and agents are seriously deficient. Little effort is made to investigate overall patterns of complaints about insurers' business practices upon which serious discipline might be based. Although the Department more effectively addresses public complaints against insurance agents, inadequate management of the investigation of these complaints has resulted in insufficient investigations and an unnecessary backlog of work. The Department's fragmented organization of investigative and disciplinary functions and a lack of uniform procedures compound these problems.

In its disciplinary actions, the Department's Legal Division has given preferential treatment to selected licensees, notably insurance companies and those insurance agents whose attorneys are former key Department officials. Such licensees have been permitted to negotiate and reduce proposed discipline in a manner inconsistent with normal Department procedure.

In several notable instances, the Department has neglected to exercise its authority to discipline license. In six cases of illegal rebates (kickbacks) by title insurers, the Department reduced by at least $344,000 the fines originally ordered because it was too costly to thoroughly investigate the cases, even though such costs could legally have been charged to the title insurers involved.

We also found that the Department has not expeditiously exercised its authority to revoke the insurance agent licenses of some convicted criminals, who continued as licensed agents for up to a year before revocation action was taken.

Our review suggested the need for basic reforms in the organization and procedures of the Department's disciplinary operations. We recommend legislative oversight to assure that appropriate reforms are implemented.

We further found that the Department's confidential records were not secured against unauthorized access.

The Department has responded to this report with a vigorous denial of much of its contents.

The Department has also charged that many sections of the report are false, and in some cases intentionally false. In response thereto, we have added Appendix C with copies of some of the data contained in our files which refute those statements.

The files of the Office of the Auditor General in support of audit reports issued are public record; hence, charges of false reporting are easily resolved by public inspection of the underlying factual data, except where disclosure thereof is prohibited by statute.

In addition to Appendix C, Appendix D characterizes the operations of the Department by one of its more vocal and informed licensees. This licensee's correspondence further underscores the Department's inertia in investigating, let alone resolving, charges of impropriety among industry licensees.

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee, we reviewed the disposition of public complaints against insurance companies and agents by the California Department of Insurance. The audit was initiated as a result of five specific allegations which are addressed in Appendix A. Since the allegations were based on the operations of the Department's San Francisco headquarters, we focused our review there.

This review was conducted under authority vested in the Auditor General by Section 10527 of the Government Code.

Background

The Department of Insurance is responsible for licensing and regulating California's insurance industry, which generated $11.9 billion in premiums in 1975. Under authority of the Insurance Code, the Department (1) regulates the admission of insurance companies (insurers) to California, (2) approves insurance rates and policies, (3) examines insurers' affairs, (4) acts as conservator and liquidator of insolvent insurers, (5) collects insurance taxes, (6) licenses insurance agents, (7) investigates public complaints about licensee misconduct, and (8) disciplines insurers and agents for violations of the Insurance Code.

The Department is directed by a commissioner appointed by the Governor for a four-year term coextensive with the Governor's term. Headquartered in San Francisco, the Department also has offices in Los Angeles, Sacramento and San Diego. In fiscal year 1976-77, the Department is authorized a staff of 389.5 man-years and estimated expenses of $8.9 million, of which $2.7 million will be reimbursed from taxes, fines and fees collected by the Department. The balance, $6.2 million, is included in the General Fund budget for the Department in the current year.

Broad Authority Under the Insurance Code

The Insurance Code provides the Department with broad regulatory authority. In addition to the usual authority granted agencies regulating sales businesses, the Insurance Code grants the Department a number of exceptional powers for the regulation of this industry. For example, the commissioner may examine and investigate the affairs of any California insurer at the insurer's expense. If he finds an insurer insolvent, he may take over and liquidate the company. The commissioner is mandated by the Insurance Code to revoke a life insurer's right to practice in California if conflicts of interest exist among the company's officers. He may deny or revoke insurance agent licenses without hearing if the agent has been convicted of a felony or violation of insurance laws, or if the agent's license was previously denied, restricted or revoked.

Higher Valid Complaint Rate Against Average Company than Average Agent

Generally, the Department receives more valid complaints against the average insurance company in California than against the average insurance agent for the same amount of insurance business. This is illustrated in the following table.

Table 1

Department of Insurance
Licenses and Complaints
1965, 1970, 1975

	1965	1970	1975
Insurers			
Number Licensed	866	973	1,083
Public Complaints Closed	13,771	15,430	19,138
Average Closed Complaints per Licensee	15.9	15.9	17.7
Producers (Agents)			
Number Licensed	181,065	185,739	201,857
Public Complaints Closed	6,657	4,278	4,245
Average Closed Complaints per Licensee	0.037	0.023	0.021
Ratio of Licensed Agents to Insurers	209:1	191:1	186:1
Ratio of Average Complaint Rate per Insurer to Complaint Rate per Agent	430:1	691:1	843:1

By relating complaint volume according to the number of licenses, in 1975 there were 186 times as many agents as companies, but 843 times as many public complaints closed per company than per agent. Therefore, in 1975 over four times as many complaints were closed against the average company as against the average agent for the same amount of business activity. Since the rate of valid complaints to total complaints is about the same for agents as companies, in 1975 over four times as many valid complaints were closed against the average company as against the average agent.

In contrast, the discipline imposed on insurance companies by the Department in this 11-year period was only a fraction of that imposed on agents, as indicated in the following table.

Table 2

Department of Insurance
Formal Disciplinary Actions
1965-1975

Action	Action Against Insurers	Action Against Agents
Revocation	1	730
Suspension	3	667
Restricted License*	not applicable	906
Suspension of Privilege to Appoint Temporary Agents	73	not applicable
Other, Including Fines	85	3,290
	162	5,593

* No actual restrictions are imposed on the licensee, but the Department may revoke a restricted license with or without holding a hearing. Some restricted licensees are required to report the financial condition of their premium trust accounts.

AUDIT RESULTS

FAVORITISM IN DISCIPLINING LICENSEES

The Department's Legal Division is responsible for all formal disciplinary action against the licenses of insurers and agents doing business in California. Legal Division staff in either Los Angeles or San Francisco may initially process such actions, but all disciplinary cases are reviewed by the chief of the Legal Division in San Francisco before final action is taken.

Our review disclosed that the Legal Division has given preferential treatment to selected licensees, notably insurance companies and those agents whose attorneys are former key Department officials. In a manner inconsistent with normal procedure, selected licensees have been permitted to negotiate the Department's charges and proposed disciplinary action, and have been allowed to reduce the penalties imposed on them below those originally specified by the Department. Appendix B, case numbers 1, 3, 5 and 8b, illustrate histories of some of these actions.

Penalties Reduced for Selected Violators

According to written instructions given to the Legal Division staff responsible for disciplining licensees, once a proposed penalty has been formally specified, "(f)urther negotiation as to reducing

the offered penalty is to be avoided...(S)uch negotiations are time-consuming and self-defeating." Such penalty offers are supposedly made only when the Legal Division has determined exactly what the appropriate penalty should be. Our review of all of the formal legal pleading records for 1974, 1975 and 1976 verified the apparent implementation of these policies in most cases, except as described below.

In at least 15 cases which originated in the San Francisco office in 1974, 1975 and 1976, the Legal Division reduced penalties for license violations after (1) a formal settlement had been offered to the licensee, (2) the licensee had already agreed to a greater penalty, or (3) the Legal Division had issued a formal disciplinary order. In 13 of these cases, the reductions were given to insurance companies and in one case to an insurance agency represented by the law firm of a former commissioner of the Department. In only one case did we find that such a reduction was given to a licensee who was not an insurance company or not represented by a former key official of the Department. (See "Agency B" in Table 3, following.)

The 15 cases in which penalties were reduced are illustrated in Table 3; 13 insurance companies received reductions, while only two agencies received reductions in penalties.

Table 3

Penalty Reductions

Licensee	Disciplinary Penalty: Formally Specified or Ordered	Disciplinary Penalty: Amended by Licensee and Accepted by Department
Agency A	$ 10,000	$ 5,000
Agency B	$ 1,431	$ 286.25
Insurer A	$ 12,500	$ 4,165
Insurer B	$125,000	$62,500
Insurer C	$187,960	$40,000
Insurer D	$ 37,500	$12,430
Insurer E	$ 70,000	$35,000
Insurer F	$ 60,000	$30,000
Insurer G	180 days*	90 days*
Insurer H	365 days*	90 days*
Insurer I	365 days*	305 days*
Insurer J	180 days*	150 days*
Insurer K	365 days*	180 days*
Insurer L	365 days*	180 days*
Insurer M	365 days*	120 days*

* Period of suspension of insurer's privilege to appoint temporary agents.

Even among insurance companies there has been a lack of uniform procedure. For example, 7 of the 21 insurers whose privilege to appoint temporary agents was suspended in 1975 were allowed to

reduce the period of suspension below that formally offered by the Legal Division. In two cases, the Legal Division ordered the suspension period to begin prior to the date of the disciplinary order.

In only 6 of the 15 penalty reduction cases did the file record offer any rationale for reducing or backdating the penalties. The Department's rationale in those six cases was that insufficient investigation had been conducted to warrant the full penalties originally ordered. These six cases are discussed in detail on page 15.

Negotiation of Penalties at Variance with Normal Procedures

A lack of uniform procedure was also indicated in negotiations between the Legal Division and selected licensees, six of whom were among those given penalty reductions as we have described.

Normally, the Legal Division prepares a formal accusation of disciplinary charges to be served on the accused licensee. Legal Division attorneys have been instructed that exceptions to normal procedures are to occur only when the Department's case is compromised after the accused has answered an official Department accusation. In most cases we reviewed, the file suggested that these procedures were implemented, except as described below.

In at least 10 of the 1975 and 1976 cases which originated in the San Francisco office, the Legal Division sent draft copies of proposed accusations and penalty offers to accused insurers or to former high Department officials acting as attorneys for accused licensees. Representatives of the accused then sent counterdrafts to the Legal Division. In each case, these negotiations resulted in deletion of important charges, reduced penalties, or stipulations to no admission of guilt. The following examples were notable:

- Prior to the completion of the Department's investigation of one case, the Chief of the Legal Division undertook such negotiations and reached a settlement with a former chief deputy commissioner of the Department who was representing the accused agent. As a result, important charges were not thoroughly investigated or included in the formal disciplinary action. (A full description of this case is provided in Appendix B, page B-2, case number 3.)

- In another negotiation case, the Legal Division permitted a former commissioner representing an accused insurer to partially revise the Department's press release on the case.

In a case of similar disciplinary negotiations the Legal Division violated its policy of permitting only the Department, not an accused, to make an offer of settlement. The following written instructions were given to a Legal Division attorney by his superior regarding the handling of an insurer violation:

> (P)lease proceed with this case. Prepare to take it to hearing and get hearing date....I offered a $5000 penalty, ...(a former commissioner is) representing them and may agree to settle but he has not made any offer. He seems to be delaying. Thus my suggestion of getting it set for hearing. If he won't pay the $5000, perhaps you could reduce it a little. (emphasis added)

Subsequent negotiations resulted in reducing the proposed penalty to $2,500, but the case is still pending.

Independent of the exceptional nature of these negotiations, they resulted in unnecessary delay. In 10 of the 11 cases noted, the Legal Division spent from three months to two and one-half years preparing drafts and counterdrafts and in meeting with representatives of the accuseds, rather than seeking public disciplinary hearings to adjudicate the matters.

CONCLUSION

The Legal Division of the Department of Insurance has given preferential consideration to selected licensees in the negotiation and disposition of disciplinary actions.

In our judgment, the selective and improper nature of these actions demonstrates a need for strict procedures to assure uniform, detached disposition of disciplinary matters by the Legal Division. The Division's current ad hoc procedure for the disposition of each case, guided solely by supervisory review is easily abused. We believe that administrative and legislative oversight of the Department's disciplinary function is also needed to assure that necessary reforms are implemented.

RECOMMENDATIONS

1. The Legal Division of the Department of Insurance should develop and follow a manual of standard procedure and standard penalties for the disposition of all discipline against the Department's licensees.

2. The Legal Division of the Department of Insurance should reconcile in writing any exceptions to standard procedure or penalty; the commissioner should approve all such exceptions.

3. The Joint Legislative Audit Committee should schedule a follow-up review by the Auditor General of the Department's disciplinary functions to begin approximately one year from release of this report.

4. The Legislature should consider creating an insurance commission to act as a permanent review board for regularly monitoring the commissioner's administration of the Department's disciplinary functions.

BENEFITS

Strict procedures for the Department's disposition of disciplinary matters would reduce the potential for preferential or improper disciplinary action. Administrative and legislative oversight will help assure impartial disciplinary actions.

INSUFFICIENT INVESTIGATION OF ILLEGAL KICKBACKS RESULTED IN SUBSTANTIAL PENALTY REDUCTIONS

In August and September 1974, the Department's Legal Division ordered six title insurers to pay a total of $493,000 in fines for illegally rebating* approximately $99,000 in valuable considerations to real estate brokers. The amount of illegal rebate was determined by a limited investigation of these title insurers' operations. Insurance Code Section 12409 holds a title insurer liable to the State for five times the amount of illegal rebate, and such was the amount ordered. However, after the insurers refused to pay the liability within ten days, the Legal Division did not seek court action as required by Insurance Code Section 12976. Instead, between November 1974 and January 1975 the Legal Division negotiated separate settlements with each title insurer, reducing the fines by 50 to 79 percent of the liability originally ordered. As a result, these insurers agreed to pay only $149,000 in fines, or $344,000 less than the liability defined by the Department. In addition, the insurers were not required to admit any violation of law.

The avowed reason for the penalty reductions was the potential expense of verifying the actual amount of illegal rebate,

* An unlawful title rebate is an economic benefit provided by a title insurer, escrow or title company as an inducement or consideration for title business, also known as a "kickback."

Some examples of illegal title rebates defined by the commissioner are: price discounts, nontitle business services, gifts, or entertainment expenses.

which had only been estimated for the purpose of the original orders. This rationale for not conducting a complete investigation ignored Insurance Code Section 12407, which authorizes the Department to charge suspected title insurers for the costs of investigating such violations. The Department regularly bills title insurers and other insurers for such expenses. Should any legal prosecution have been necessary, we believe the potential $344,000 revenue from additional fines would have offset the legal expenses.

The Department's original estimates of the amount of illegal rebate covered only selected offices of the title insurers, and for only a three-month period. A wider examination may have indicated larger rebate amounts than those found by the Department.

CONCLUSION

The Department of Insurance did not conduct sufficient investigations of six title insurance rebate cases in which only $149,000 in fines was recovered. As a result, the Department reduced the fines by $344,000.

RECOMMENDATIONS

1. Where adequate initial evidence of Insurance Code violations exists, the Department should investigate to the full extent of its authority.

2. The Department of Insurance should consistently exercise its authority to charge insurers (and title insurers) for the costs of investigating Code violations.

3. The Department of Insurance should conduct sufficient investigation before taking legal action to discipline licensees.

FAILURE TO EXPEDITIOUSLY REVOKE LICENSES OF CONVICTED CRIMINALS

The Insurance Code authorizes the Department to revoke without hearing the agent licenses of convicted felons, convicted violators of insurance laws, and agents whose licenses were previously denied, restricted, or revoked. In 1975 and 1976, the Legal Division used this authority to summarily revoke two licenses in proceedings by the San Francisco office.

However, in 17 other San Francisco cases during these two years, the Legal Division did not summarily revoke the licenses of convicted criminals. Instead, the Legal Division pursued the regular disciplinary hearing process, which resulted in delays of 23 to 357 days in the revocation of these criminals' licenses. Twelve of these criminals still held active licenses until finally revoked. In fourteen of these cases, the files indicated the licensee did not offer evidence justifying continued license.

Table 4 compares the two San Francisco cases in which the Department exercised its summary revocation powers with the 17 San Francisco cases in which the Legal Division pursued the normal disciplinary process.

Table 4

Cases in Which the Department
Had Authority to Summarily
Revoke Agent Licenses

San Francisco Office, 1975-1976

Case	Nature of Conviction	Date of Conviction	Days Delay Before Revocation
License Summarily Revoked			
Agent A	Felony check bouncing	3/08/76	none
Agent B	No conviction. Previously revoked licensee's new license revoked for failing to remit $688 in premium from 4 insureds.	n/a	none
License Revoked Through Hearing Procedure			
Agent C	Armed bank robbery	10/15/74	43
Agent D	Felony check bouncing	10/10/75	150
Agent E	Felony grand theft	10/16/74	142
Agent F	Felony forgery	--*	237
Agent G	Felony check bouncing	5/15/75	88
Agent H	Three separate misdemeanor convictions and one felony conviction for petty theft and fraud.	--*	70
Agent I	Felony grand theft	3/19/75	38
Agent J	Felony fraud	4/15/75	35
Agent K	Misdemeanor insurance theft	10/09/75	40
Agent L	Felony insurance fraud	9/25/75	33

* Licensee lied on license application regarding prior convictions noted.

Case	Nature of Conviction	Date of Conviction	Days Delay Before Revocation
Agent M	15 counts felony grand theft	12/23/75	118
Agent N	3 counts felony forgery	--**	42
Agent O	Felony burglary	--*	28
Agent P	Felony grand theft: false insurance claim	5/31/74	115
Agent Q	2 separate felony grand theft convictions	(1) 4/28/75 (2) 5/30/75	115
Agent R	Felony grand theft	5/21/75	23
Agent S	2 counts felony grand theft	10/18/72	357

* Licensee lied on license application regarding prior convictions noted.
** Date not available.

In addition to the unnecessary public hazard created, the Legal Division incurred unnecessary costs to revoke the 17 criminals' licenses through the regular disciplinary procedure. This was especially true in the three cases taken to formal disciplinary hearing before the Office of Administrative Hearings which charges approximately $500 per hearing day for its services.

CONCLUSION

Despite selective use of its authority to summarily revoke agent licenses, the Legal Division failed to expeditiously revoke the licenses of 17 convicted criminals in matters originating in the San Francisco office in 1975 and 1976.

RECOMMENDATION

The Legal Division of the Department of Insurance should consistently exercise its authority to summarily revoke the licenses of agents convicted of felonies or violations of insurance laws.

BENEFITS

Summary revocation of criminals' agent licenses would reduce public hazard and save the Legal Division the expense of pursuing the regular disciplinary hearing process.

INADEQUATE MANAGEMENT OF INSURANCE AGENT INVESTIGATIONS

The Department's Investigation Bureau is responsible among other duties for receiving and investigating public complaints to determine whether insurance agents have violated the Insurance Code. Our review disclosed that the Bureau does not administer this function effectively. Inadequate supervision, training and procedures have resulted in inappropriate and incomplete investigations, an unnecessary backlog of work, and low staff morale.

Inadequate Supervision

Because of time pressures and the Bureau's procedures for reviewing investigative work, the Bureau's supervisorial system is inadequate. Routine supervision of investigative staff occurs through a system of senior investigator review of cases investigated by junior staff, except in Los Angeles where a supervisor also reviews all closed investigation files. There is little operational supervision of any of the investigators, largely due to the time pressures of each investigator's caseload. As a result, senior and supervisory review usually occurs after the investigator has interviewed witnesses and gathered documents according to his own initiative. The file record therefore tends to support only those conclusions drawn by the investigator. Even if a reviewer believed further investigation were necessary, he is unlikely to recommend reopening a poorly conducted investigation

given (1) the pressure to close cases, (2) the probable embarrassment of reinterviewing witnesses or rereviewing an accused agent's files, and (3) the knowledge that a junior can hold a case until he is rotated to a more lenient senior. In any case, neither the seniors nor the supervisors have much time to divert from their caseloads to review other investigators' work.

Inadequate Training

Much of the Bureau's lack of supervision might be compensated by having adequately trained investigators, but the Bureau has only recently made any attempt at formal training. Although the majority of the investigators have no investigative experience prior to working for the Department, no formal training has been provided to any but the most recent recruits. Instead, the Bureau relies on a system of probationary oversight and direction from senior investigators. This system is inadequate because the senior staff have had virtually no supervision or training upon which to base direction to juniors. What investigative skills are acquired result primarily from unguided experience. As a result, there is a wide discrepancy among the investigators' skills and approaches to cases, and there is no necessary relationship between seniority and the quality of investigative work.

In 1976, the Bureau began developing a training program for new recruits, many of whom have had neither investigative nor insurance industry experience. We believe the outline of the program appears promising, but the training is provided to only the newest recruits who are still tutored by the inadequately trained and supervised seniors.

Inadequate Investigations

Paralleling the inadequacies in supervision and training are indications of inadequate and inappropriate investigative work. Attorneys responsible for acting on investigation reports told us that investigators do not properly investigate or report the facts in many cases. The chief of the Legal Division told us in a recorded interview: "We do have, unfortunately, what I would describe as not a terribly experienced staff of investigators."

Our review tended to corroborate these opinions. In 25 percent of a random sample of 102 1975 and 1976 investigations by the San Francisco Bureau office, there was no evidence the investigator had even determined whether the accused agent was a Department licensee.

In 27 percent of the sample cases, the file indicated the investigator relied solely on the accused agent's denial of wrongdoing to close the case, despite the judgment of the chief

investigator that this is improper. The investigator's procedure is to obtain such a statement of denial even though, in the words of a former chief of the Department's disciplinary functions, "nothing will usually be gained by contacting the licensee involved for a denial."

Twenty-six percent of the sample cases were closed on the basis of restitution to the insured even if a violation was suggested. Yet Legal Division instructions to disciplinary attorneys specify that "there is no merit to restitution in lieu of disciplinary action...If the only penalty is payment of the complainant's damages, the licensee has been required to do no more than he would legally be compelled to do and the Department has let him go with no penalty whatsoever."

Procedural Inadequacies

Some Bureau procedures compound the inadequacy of investigation or inhibit effective disciplinary action. For example, without consulting the Legal Division, the Bureau disciplines agents through oral warnings and warning letters. The oral warnings are not adequately documented to be of legal value in future disciplinary action. Warning letters are issued in some cases which the Legal Division would otherwise pursue. Because the investigators do not consistently report prior complaints against agents, we concluded that the Legal Division

may never know of some prior warnings by the Investigation Bureau. Indeed, the files on the estimated 89 percent of all investigations not referred to the Legal Division are destroyed after two years, so records of many investigations and warnings are unavailable to the Legal Division in subsequent disciplinary proceedings. In the San Francisco office, this problem is compounded by the need to search four and as many as five separate filing systems to find all disciplinary investigation files on an agent within the last two years.

Investigators are discouraged from reporting code violations because of some Bureau procedures. Only those cases in which a violation is found require a senior investigator to seek supervisory review, except in Los Angeles where a supervisor reviews all closed cases. This disincentive for finding violations is encouraged by (1) the need to prepare a formal investigation report only in cases where violations are to be referred to the Legal Division, (2) the pressure on each investigator to reduce his case backlog, and (3) the investigator's belief that the quantity of cases closed is more important than the quality of investigation in determining advancement within the Bureau. Many of the investigators in both San Francisco and Los Angeles are inclined to close the easiest cases and postpone those which might require extensive investigation. Generally, the easiest cases are those which do not indicate Code violations. Without a system of monitoring the age of assignments, the Bureau has no regular means for assuring that the more difficult cases are not postponed indefinitely.

The Bureau has also not developed appropriate priorities for the disposition of cases. Few formal priorities have been developed, and those few are based more on the source of the complaint than on the seriousness of the violation. According to the chief investigator and some of his investigators, swiftest action on a complaint usually results in cases in which the original complainant persists most vocally. It is also the Investigation Bureau's written policy to give priority to complaints referred by legislators and the Governor's office. We believe that the virtual lack of a system of formal priorities, and the inappropriateness of what few priorities there are for disposing of cases, result in insufficient attention to investigating serious violations. This conclusion was corroborated by the following quotation from a memo by the chief investigator to his staff:

> The Code is full of Sections which we don't pursue actively. Control is maintained by outside persons not being aware of this.

The entire case file on one insurance agent exemplifies the result the Bureau's inadequate management has had on the quality of investigation. From 1969 through 1976, the Bureau's San Francisco office received 19 public complaints about this agent's insurance practices. Each of 11 Bureau investigators handled at least one of these investigations, all of which were approved through the Bureau's review procedures. In 16 of the 19 complaint

investigations, the Bureau closed the case without investigating serious charges, corroborating the agent's denials of wrongdoing, or forwarding to the Legal Division evidence of serious violations. In one case, the Bureau closed the investigation "no violation" on the basis of the agent's lack of appropriate records--itself a violation of the Insurance Code. In another case, an investigator reported that both the agent and an insurer had knowingly misrepresented insurance coverage--a misdemeanor Code violation--but the Bureau took no action on the ground that neither the agent nor the insurer was selling that type of policy anymore.

Each of these 19 investigations involving one agent is outlined in Appendix B, page B-5, case number 4. Appendix B includes other examples of inadequate investigation (case numbers 3, 6 and 10).

Unnecessary Backlog

As noted on pages 22-26, some of the Bureau's problems result from time pressures to process a backlog of pending cases. According to the chief investigator, the maximum caseload an investigator can normally handle is about 70 to 75 assignments. The actual caseload is almost universally higher, up to 135 assignments per investigator.

The chief investigator also said the backlog is unnecessary. In a memo prepared at our request, he said, "When fully trained, the existing staff might be able to handle the case input with careful

management." We believe that the unnecessary backlog is exacerbated by the inadequate procedures, supervision and training described above.

Some of the Bureau's unnecessary operations compound the backlog of cases. Some complaint matters are investigated in which the Department has no jurisdiction. For example, Insurance Code Section 775 limits the Department's authority to investigate complaints about property insurance sales to complaints filed within three months of the sale, and made only by the property seller, buyer, or lender. We found three cases where the Investigation Bureau investigated complaints made by persons other than the lender, buyer, or seller; or up to two years after the sale. The Bureau also has a policy of having accused agents sign statements prepared by investigators, even though such statements are of little or no value as evidence to Legal Division attorneys.

Low Staff Morale

Some of the investigative staff reported that work pressures and inadequate supervision and training accounted for low morale, especially in the Los Angeles office. The problem is more severe among the senior investigators, who have little opportunity for advancement even if they are properly trained. We believe that rewards for self-improvement are essential to inspiring high quality work from personnel.

CONCLUSIONS

The Department's Investigation Bureau is inadequately managed. As a result, potential Code violations are inadequately investigated, there is an unnecessary backlog of cases and staff morale is poor.

We believe that the seriousness of the Investigation Bureau's problems demonstrates the inability of its management to effectively direct the investigation of complaints about insurance agents. The chief investigator agreed that supervision was breaking down in the San Francisco office, that until the new recruit program there had been virtually no formal training, and that the unnecessary case volume pressured staff to close cases quickly. Some of these problems have been known to Bureau management since at least 1964.

In our opinion, reform will require operational direction from outside the Bureau. We believe it would be appropriate for a unit of Department attorneys to take over direction of the investigation of complaints against insurance agents. Legal Division attorneys are already responsible for determining the value of information gathered by investigators, and attorneys should be more qualified than investigators in determining the evidentiary requirements for proving Code violations and the appropriate

disposition of complaints. Although investigators may be trained to initially screen public complaints and conduct field investigation tasks, we believe that all investigations of agent violations should be initiated, supervised and resolved by Department attorneys. We estimate this would require four additional staff attorneys, which could be acquired at no new cost to the Department from the 17 budgeted positions expected to be unneeded in fiscal year 1976-77 (and 1977-78).

For reasons discussed on page 43 of this report, we believe that a complete reorganization of the Department's investigative functions is also necessary. The following recommendations apply to reforming the investigation of complaints against agents no matter how that function is organized.

RECOMMENDATIONS

The Department of Insurance should:

- Assign Department attorneys to direct the investigation of Code violations by insurance agents.

- Develop a training and procedures manual in conjunction with retraining of the entire investigator staff.

- Develop and follow a formal system of priorities for the assignment and disposition of public complaints against insurance agents, such as the following:

First priority	Complaints with the strongest evidence of the most serious Code violations
Second priority	Oldest complaints and assignments suggesting Code violations
Third priority	More recent complaints suggesting Code violations
Fourth priority	All other matters

- Develop a central filing system for all complaints and discipline against each agent.

- Provide positive incentives for rewarding superior investigator performance.

The Joint Legislative Audit Committee should schedule a review by the Auditor General of the Department's investigation of complaints against insurance agents, to begin approximately one year from release of this report.

BENEFITS

Outside direction and retraining would assure more competent direction of the investigation of public complaints and the substantiation of Code violations by insurance agents. Improved procedures would encourage more effective management. Legislative oversight would assure the implementation of appropriate reforms.

INADEQUATE INVESTIGATION OF INSURERS' BUSINESS PRACTICES

The Department makes almost no effort to investigate patterns of public complaints of insurers' market conduct upon which serious disciplinary action could be taken against an insurer. As a result, significant patterns of possible misconduct have not been investigated.

Serious Discipline Requires Patterns of Misconduct

The Insurance Code gives the Department only limited authority to discipline an insurer for individual instances of unfair market practices, such as misrepresenting a policy or treating a policyholder unfairly. Serious discipline, such as suspending an insurer's license, may be imposed only when the Department has found a pattern of misconduct which indicates a regular practice of insurer bad faith, fraud, or policyholder mistreatment.

Department Does Not Analyze Primary Data Source for Detecting Patterns

The Department's most important source of information about possible patterns of insurer unfair practices is its file of public complaints against insurer's disposition of individual insurance policies. Two units within the Department review such

complaints. The Policy Services Bureau receives and acts on public complaints, and the Surveillance and Analysis Division monitors complaint patterns. However, neither of these units effectively analyzes the complaints for patterns of insurer misconduct.

The Policy Services Bureau does not regularly review its complaint files to determine patterns of insurer misconduct. This is because the Bureau's staff does not see this as the Bureau's role. Instead, the Bureau acts as a mediator between insurers and insureds to help resolve policy contract disputes. Although the Department has no authority to arbitrate such disputes, the Bureau's management sees its function to use "jawboning" and "friendly persuasion" to mediate fair settlements.

Even when the Department's Examination Division requests information on complaint patterns, the Bureau has often replied that it has no information of value on insurers responsible for extraordinary complaint volumes. From our random sample of 70 insurers, Policy Services responded that it had "no information of value" to four of eight such requests made for insurers with some of the highest complaint volumes, especially considering the insurer's volume of business.

The Department's Surveillance and Analysis Division (SAD) has responsibility for monitoring patterns of complaints indicated in Policy Services files, but this activity comprises

less than one percent of two SAD staff members' time. SAD's review is further limited to those complaints filed in the Los Angeles office and to selected referrals of agent investigations conducted by the Investigation Bureau. Regular statewide complaint analysis is thus inhibited, and SAD's unfair practices analysis does not regularly include a review of complaints lodged against an insurer's Northern California operations.

SAD's review of investigations of complaints against agents represents the Department's only effort to determine patterns of collective misconduct by the agents of particular insurers. SAD receives only those investigation referrals in which the Investigation Bureau found evidence of a Code violation. Yet SAD analysts believe that all complaints are important in determining patterns, especially in view of the limited investigation of cases by both the Investigation and Policy Services Bureaus.

As a result of staff and procedural limitations, in 1975 and 1976 SAD did not refer any patterns of complaints about insurer unfair practices to the Examinations Division for investigation or to the Legal Division for disciplinary action. In one 1976 case, there is no record of the chief of SAD having referred a verified pattern of insurer misconduct to the Legal Division, as recommended by SAD analysts. As a result, the insurer has not been disciplined for systematic illegal procedures (see Appendix B, number 10, page B-15).

Inadequate Field Investigation

Unlike the Investigation Bureau's handling of complaints against insurance agents, the Policy Services Bureau does not conduct field investigation of complaints about insurers. Instead, Policy Services mediates policy disputes through telephone and mail correspondence.

The Department has only rarely conducted a special investigation of an insurer's actual operations or complaints received by the insurer from its policyholders. In 1976, the Department conducted three special insurer examinations called "market conduct surveys." As of March 1977, no formal action had been taken against the two insurers in which the surveys had been completed and the suspected misconduct verified. According to Policy Services staff and Bureau files, the high complaint volume against one of these two insurers had been recognized for several years. However, the special investigation was not conducted until press publicity focused on the insurer's mistreatment of policyholders.

The Department relies on its triennial examinations of each insurer to disclose any problems or illegal practices. However, as noted on pages 35 and 36, the Examination Division is not adequately advised about complaint rates to focus attention on particular insurer problems. Further, the examiners' primary

focus and training are in financial analysis. We believe that public protection requires immediate investigation of insurer misconduct disclosed by public complaints, rather than waiting up to three years for a regular examination.

Complaint Files Indicate Significant Patterns

Our review of Policy Services and Investigation Bureau's complaint records indicated important patterns of complaints made against particular insurers or their agents. We reviewed the Policy Services records of complaints closed in 1976 for a random sample of 70 of the estimated 500 insurers against which public complaints were made. Fourteen percent of the insurers sampled were responsible for 81 percent of the Policy Services complaints and a like percentage of all valid complaints, as determined by Policy Services staff. Four of the ten insurers with the highest complaint rates had less than average business volumes, so the high complaint volumes were especially notable. In many cases, the complaints focused on particular areas of possible misconduct by an insurer. Yet Policy Services referred the complaint pattern of only one of the sample insurers for departmental action.

Other potential patterns of insurer misconduct can be determined from public complaints against the agents of particular insurers. In our random sample of closed investigations of complaints against agents in 1975 and 1976, agents of 11 percent of the

insurers were responsible for 35 percent of the complaints against all agents. This pattern was even more significant because many of these insurers had disproportionately small business volume compared with the volume of complaints against their agents. Further, nine of the ten highest complaint rates were against the agents of life insurers. We conclude that there are significant patterns of public complaints against the agents of particular insurance companies, especially life insurers.

The highest agent complaint rate in our sample involved a small life insurer which was responsible for 11 percent of all complaints against insurance agents. Coincidentally, the Investigation Bureau relied on correspondence with this insurer's officials to settle public complaints against its agents--an unusual procedure despite 63 complaints about misrepresentations by the insurer's agents.

CONCLUSIONS

The Department of Insurance has neglected to investigate patterns of insurer market misconduct suggested by public complaints against insurers. As a result, significant patterns of possible misconduct have not been analyzed or investigated.

In our judgment, the Department's general neglect in investigating patterns of insurer market misconduct is symbolized by the mistaken priorities of the Policy Services Bureau. The Bureau is the most informed about potential patterns of insurer misconduct, yet it seeks only to resolve individual disputes. We believe that the Policy Services Bureau should detect, analyze and investigate patterns of complaints against insurers.

The Policy Services files are already organized to reveal such patterns, and the Department's computerization of these data should permit even more convenient, sophisticated analysis of complaint patterns. We propose that the Policy Services staff capitalize on the availability of these data. Norms of typical complaint rates should be developed and the Policy Services staff should conduct field investigations of the operations and files of insurers with abormally high rates. Policy Services staff should be qualified to conduct such investigations, since many of them are former Department investigators. The Policy Services Bureau's experience with "market conduct surveys" could provide a basis for an investigative methodology.

We believe that this analysis and investigation should be focused in one unit, and it should be the one closest to the public. Therefore, we suggest that the Surveillance

and Analysis Division's (SAD) market conduct monitoring be transferred to the Policy Services Bureau. The Bureau could forward to SAD the results of analysis and investigation for SAD's use in analyzing insurer solvency. Policy Services could also refer substantiated patterns of insurer misconduct to Department attorneys for appropriate disciplinary action.

Such monitoring and investigating of complaint patterns should not significantly increase budgetary requirements. The Department's new computerized data system could be programmed to automatically report significant patterns without requiring manual staff review. More significantly, the costs of conducting field examinations of complaint patterns can be charged to the insurer investigated.

Beginning on page 43 of this report we recommend that the Department's investigation of complaints against insurers and those against agents be combined. The proposed reforms of the Policy Services operation are independent of the advisability of such a reorganization.

RECOMMENDATIONS

1. The Department of Insurance should direct the Policy Services Bureau to detect and investigate patterns of insurer market misconduct.

2. The Department of Insurance should centralize the analysis of insurer market conduct in the Policy Services Bureau.

3. The Joint Legislative Audit Committee should schedule a review by the Auditor General of the Department's analysis and investigation of insurer market conduct, to begin approximately one year from the release of this report.

BENEFITS

Investigating patterns of insurer market misconduct would increase public protection at little increase in cost. Centralizing the analysis and investigation of insurer market misconduct would provide an efficient organization of this function. Legislative oversight would assure that appropriate improvements are implemented.

INEFFECTIVE ORGANIZATION OF DISCIPLINARY FUNCTIONS

The organization of the Department's investigation of public complaints about insurance agents and insurers is fragmented, and disciplinary functions lack coordination. Some investigative functions are combined with unrelated activities. As a result, the organization of these functions contributes to the ineffectiveness of the Department's investigation and discipline of licensees described earlier in this report.

Fragmented Investigative Functions

The Department's investigation of public complaints is divided into separate bureaus according to the type of licensee. Public complaints against insurance agents are handled by the Investigation Bureau, and those against insurers by the Policy Services Bureau. However, many investigations by either bureau require inquiries crossing these organizational boundaries. For example, if the Investigation Bureau receives complaints about an agent's failure to deliver a policy or refund a premium, the cause of the problem may be with the company, in addition to, or instead of, the agent. Similarly, the Policy Services Bureau may find that the reason a complaint was lodged against a company for failing to pay a claim was that the agent never submitted a policy application to the company.

A coordinated approach is especially important in determining patterns of systematic malpractice by an insurer's agents. The

Investigation Bureau does not cross-index its files of complaints against agents according to the insurer represented because the Bureau is not responsible for monitoring insurer misconduct. Instead, the Investigation Bureau refers those cases in which an agent violation was detected to the Surveillance and Analysis Division, which is primarily concerned with insurer's financial solvency.

Supposedly, the coordination of the Policy Services and Investigation Bureaus occurs through their organizational parent, the Consumer Affairs Division. However, the Division Chief is also the Department's conservator and liquidator of insolvent insurers. He spends approximately three-fourths of his time occupied with this unrelated activity. Operational management of the Policy Services Bureau is left to its northern and southern California supervisors, and management of the Investigation Bureau is left to its chief investigator.

The division of responsibility between these two bureaus also permits the difference in their investigative methods. The Investigation Bureau conducts field investigations of agent operations to determine the validity of public complaints against agents. In contrast, the Policy Services Bureau seeks only to mediate disputes between insureds and insurers through telephone and mail correspondence with the parties.

Lack of Coordination of Disciplinary Actions

Although formal disciplinary action is supposed to be the exclusive responsibility of the Legal Division, disciplinary warning letters are issued independently by the Investigation Bureau, and oral warnings are given to licensees by both the Policy Services and Investigation Bureaus. No centralized file is kept of the complaints and actions taken against each licensee; each bureau or division keeps its own records, which are usually kept separately in each of the bureau's offices in various parts of the state. Complete records are not kept of many of the oral warnings, so even the bureau which made the warning cannot always verify it.

CONCLUSIONS

The Department's investigation and discipline of licensee market misconduct are organized ineffectively. The lack of coordination inhibits effective investigation and discipline of licensees.

In our judgment, there is no justification for multiple investigative and disciplinary operations involving the disposition of public complaints against insurance agents and insurers. Public complaints are made on the basis of the entire insurance transaction, and we believe there is no reason why the Department should not provide a single,

uniform service to receive and act upon complaints against all licensees.

We believe that efficient and effective uniform disposition of complaints would be served by merging into a coordinated unit the Policy Services and Investigations Bureaus, and the Legal Division attorneys responsible for most disciplinary actions. The desirability of having staff attorneys supervise the investigation of agent violations has already been described (see page 30). The advantages of adding the Policy Services function to the unit are several. First, this would provide a single reception point for all public complaints lodged with the Department. Second, centralization assures a uniform, coordinated approach to the investigation and discipline of industry practices regardless of the type of licensee. Third, administration of one unit should be less expensive than the current administration of three units. Such a centralization would be all the more convenient because the Policy Services analysts and the Investigation Bureau's investigators are already in the same personnel classification, Insurance Officer. Some of the Policy Services staff have some investigative experience. Since the investigators should be retrained anyway (see page 23), it would not be inconvenient to pool the training effort among all the investigative staff of the new combined market practices unit.

In order to assure the unit's independence from unrelated functions, it should be headed by an individual who reports

directly to the Chief Deputy Commissioner or the Commissioner. Such a reorganization would virtually eliminate the present Consumer Affairs Division, except for the conservatorship and liquidation function, which should be independent of disciplinary functions. The remaining functions of the Legal Division could remain intact.

RECOMMENDATIONS

The Department of Insurance should:

- Consolidate the Legal Division's disciplinary attorneys and the Consumer Affairs Division's Policy Services and Investigation Bureaus into a separate market conduct unit.

- Place at the head of the market practices unit an individual directly responsible to the Chief Deputy Commissioner or the Commissioner.

BENEFITS

Centralization of these functions would provide a basis for efficient, uniform disposition of public complaints and disciplinary action against all Department licensees.

INADEQUATE FILES SECURITY

Our review disclosed a lack of files security at the Department's San Francisco and Los Angeles offices. The central files room in San Francisco is one of the Department's two main libraries of completed cases for nearly every facet of the Department's operations, including confidential records of disciplinary actions and financial analyses of insurer solvency. During our review, we noted the following deficiencies in the security administration of the central files room:

- The room was located behind unlocked, unsigned doors near the main public reception area.
- Public access to the room could not be detected from the file clerk's station in the room.
- Often, the file clerk was not present to monitor access to the files.
- Numerous files we requested were either missing with no record of their location, or the location record was inaccurate.

At our suggestion, the Department locked the door nearest the public reception area, and the other door has now been signed "Department of Insurance Employees Only," which should solve the first two of the problems listed above.

The examiners' San Francisco workpaper library containing confidential data was also unsecured. There was no door at the entrance to the room, to which public access is restricted only by general staff surveillance.

According to the chief of the Legal Division, such security problems have led to at least one stolen case file. Department staff also complained to us of the inefficient delays in searching for files.

Our review of the Los Angeles office indicated much better files security there. However, the central files room in Los Angeles is apparently not locked at any time, and during our review the room was not monitored.

CONCLUSION

The Department of Insurance has neglected to provide adequate physical security and control over confidential records in the Department's San Francisco headquarters. In the Los Angeles office, the central files room is not properly secured or monitored.

RECOMMENDATIONS

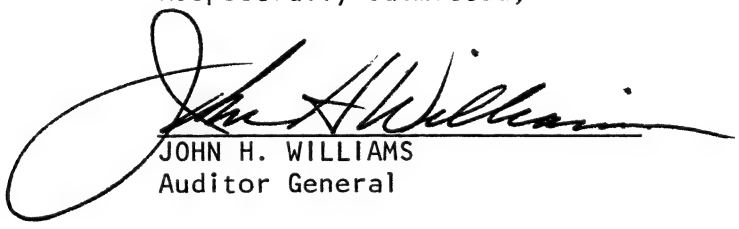
At its San Francisco headquarters, the Department of Insurance should immediately:

- Develop and enforce procedures for access to and removal of files from the central files room, including proper recording of file location.

- Store examiners' workpapers in locked storage, such as in a locked room.

At its Los Angeles office, the Department should lock the doors of the central file room to unauthorized access when a monitor is not stationed in the room.

Respectfully submitted,



JOHN H. WILLIAMS
Auditor General

Date: April 15, 1977

Staff: David B. Tacy
J. Peter Bouvier

STATE OF CALIFORNIA EDMUND G. BROWN JR., Governor

DEPARTMENT OF INSURANCE
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(213) 736-2551

April 16, 1977

John H. Williams, Auditor General
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Suite 750, 925 L Street
Sacramento, California 95814

Dear Mr. Williams:

In response to your letter of April 12, 1977, please consider this the response of the Department of Insurance to the Auditor General's Report (#292). Your auditor(s) have been in the Department of Insurance since late last year. On the afternoon of April 12, 1977, your auditor called my secretary in San Francisco and indicated that he would deliver three copies of the draft report the following morning at 8 o'clock. He appeared at 8 o'clock and gave my secretary a single copy of the report, along with your cover letter dated April 12, 1977. I began a review of the report and discerned that it would take considerable time to deal with it properly. Because I was to be involved in a whole day hearing in Los Angeles on April 14, it would not be possible for me to produce adequate written response within the time limit of three working days. I, therefore, called you and advised you of the time problem and requested an extension to allow a full and proper response to the report. You advised that you did not have authority to grant an extension of time but that you would communicate my request to the Joint Legislative Committee and let me know of its decision. The following morning your secretary reached my Los Angeles office with the message that the request for extension of time had been denied. Subsequently, the deadline was extended from 5 p.m. Friday, April 15, to 8 a.m. Monday, April 18.

It is indeed unfortunate that a report which culminates some four months of effort on the part of your staff is not deserving of full discussion before your "draft" report becomes your final report. The report is replete with error, such as on page 4, the reference to our budget and the reference to the Commissioner's ability to liquidate a company if he finds an insurer insolvent.

The first thing I looked for in the report was some reference to your letter of July 27, 1976 addressed to Chairman Cullen, recommending an audit of the Department of Insurance and which served as the reasons for your audit. The first two paragraphs of that letter read:

> "We have surveyed selected activities and operations of the Department of Insurance, resulting in the identification of five areas which appear to require an in-depth examination.
>
> "We have learned from sources available to us that the following conditions exist within the Department:"

The five specific allegations which followed are set out in pages A-1, 2 and 3 of the report. From the findings set out on those pages, you are now acknowledging that your survey of "selected activities and operations of the Department of Insurance" and your "sources available to us" were highly, if not totally inaccurate.

In asserting that the Department of Insurance is deficient in its surveillance of the market conduct of insurers, the report fails to acknowledge the attention given to this important activity by our Examination Division. We make further reference to this in the attached commentary at reference pages 34-37.

The report alleges that the Department gives preferential treatment to licensees whose attorneys are former key Department officials. The auditor has picked out a number of selected cases whereby licensees represented by attorneys who happened to have been former key Departmental officials, negotiated a reduced suspension or fine. He has failed to document the number of incidents where attorneys who were not former key Departmental officials have also negotiated changes in the suspension or fine. There are a large number of such cases. By failing to document them, there can be no basis for the Auditor General's allegations that there is preferential treatment. Negotiation of penalty reductions is common practice between the legal profession and district attorneys, city attorneys and all government regulatory agencies and very often leads to a more appropriate and timely resolution of the matter.

The criticism of our handling of the title insurance cases does not square with the facts as we view them. There is further comment on the attachment at reference page 8, item (3).

With reference to our failure to revoke the agent licenses of some convicted criminals, the auditor has looked at only part of the law and has ignored related court decisions. Please refer to the attached commentary at reference pages 18-21.

Certain of the suggestions made with respect to improvement in the organizational structure and lines of supervisory authority could well have merit and will be given full consideration.

The critique of our file security is in order. We have already made certain of the suggested improvements. See attached at reference pages 48-50.

If you would care to discuss this further, I will be available.

Yours very truly,

WESLEY J. KINDER
Insurance Commissioner

WJK:mk
Attachment

DEPARTMENT OF INSURANCE RESPONSES

TO AUDITOR GENERAL DRAFT REPORT (#292)

The following are responses to specific items in the report. Our failure to respond to one or more items should not be construed as agreement with such items. As stated in my cover letter, we simply have not had sufficient time to prepare a response to each issue raised.

Page 3

The report refers to the resolution of the Joint Legislative Audit Committee and in Appendix A the five allegations are identified. It would appear proper to include a copy of your July 27, 1976 letter to Chairman Cullen in the report.

Page 4

The reference to budget reflects the method of funding the Department of Insurance and is not a true picture of revenue flow. On page 3, it is acknowledged that the Department is responsible for the collection of insurance taxes. In 1976, that amounted to more than $200 million.

The statement is made, "If he finds an insurer insolvent he may take over and liquidate a company." This implies that such action is summary when it is not. It can only be accomplished after a full hearing in Superior Court.

The reference to denying or revoking agent licenses without hearing if the agent has been convicted of a felony or violation of insurance laws is responded to later. (See response at reference pages 18-21.)

Pages 5-6

The word "valid" is used in the heading of this section and is used again on page 6 where it is underlined in two instances. In the table on page 5, the word "complaint" is not qualified by the word "valid." The distinction is not explained.

The table attempts to show a ratio of average complaint rates per insurer to average complaint rates per agent. Any such comparison is invalid. Complaints against licensed agents and brokers are usually cases of fraud, misrepresentation or misappropriation of funds, and the Insurance Code clearly sets our procedures for suspension or revocation or other disciplinary action to be taken against such licensees. Complaints against insurance companies are much more numerous because they involve the millions of claims that are settled by insurers each year.

Fifty percent of the complaints against insurers are found to be unjustified.

The Policy Services Bureau first attempts to get a proper settlement in those cases that are justified and in 1976 obtained over $5 million for such claimants. It could happen that a company might have, say, 100 complaints during a year. However, if that company had settled that year several hundred thousand claims, the number of complaints (100) would not be sufficient to sustain an action against the company. Complaint frequency information is sent to our Examination Division; and, in the course of its regular examinations, it will determine whether the company, as a general practice, treats claimants unfairly. If it is so found, a hearing would be warranted. Our examination of the overall company records rarely finds a pattern of improper claim settlements that would warrant a suspension or revocation which could be sustained in court but does warrant discussions with the company as to its adjustment procedures. The Department has sought authority to fine insurers for such practices, but the Legislature has not passed the bill. A similar bill has been introduced this year.

In those cases where the examination of the company shows any tendency towards unfair claim settlement practices, discussions are held with the company and the condition is

remedied to the satisfaction of the Department, which is the only action the law permits us.

It should be noted that the ratio of complaints to premium volume varies by line of business. For example, the 19,138 complaints of 1975 break down as follows:

Life	1,711
Fire and Marine	2,125
Disability	7,231
Liability and Workers' Compensation	1,366
Automobile	5,842
All Others	863
	19,138

To produce a table such as that on page 5 without recognizing how and <u>why</u> the number of complaints varies by line of business is a wasted effort.

<u>Page 7</u>

Comments of "favoritism" of "selected licensees is unfair and not supported by the evidence.

The staff makes initial recommendations to the bureau supervisor whenever a penalty is to be offered to the licensee as an alternative to a public hearing. Once the supervisor has approved the proposed penalty, it is communicated to the licensee;

and the staff is not permitted to independently negotiate for a different penalty. Any request by the licensee or his attorney for negotiation must be taken up by the attorney with the bureau supervisor and the Chief of Legal.

Page 8

It is impossible to expect that all proposed penalties are always appropriate. Individual attorney's attitudes vary; hence, the practice of review by the bureau supervisor prior to issuance.

The comments relating to the 15 cases which were not handled in accordance with normal procedures are unfair in that the auditor fails to distinguish among the different legal proceedings involved. It is not appropriate to apply identical procedures to all disciplinary cases. Three types of inappropriate actions are identified on page 8: (1) a formal settlement had been offered; (2) the licensee had already agreed to a greater penalty; or (3) the Legal Division had issued a formal disciplinary order.

Item (1): Although a proposed penalty has been offered, the licensee may wish to submit additional evidence in mitigation or even to disprove the charges. That opportunity cannot be denied to the licensee solely because a penalty has been proposed.

Item (2): Could not be identified.

Item (3): It is presumed that this reference is to the six title insurance cases. Although the document issued in that case is titled "Demand Order," it is in the nature of an Accusation containing certain charges of unlawful rebates. These six cases are also discussed on pages 15-16 of the report. The comments of the auditor reveal failure to have analyzed the evidence developed by Legal. The charges of unlawful rebates were made after the attorney handling these cases held investigative hearings to which these insurers were subpoenaed with orders to appear and produce certain information. It is true that the material thus obtained revealed rebates; but the amounts alleged in the orders were, at best, educated guesses--made with the full expectation that the insurers would challenge our conclusions. The criticism that field investigation should have been made is invalid. The absence of a field investigation was not predicated on the cost involved but rather on the impossibility of establishing rebates from the insurers' records. The use of the investigative hearing technique served well in this case since the officers were placed under oath and asked to reveal what their companies' practices were. It is doubtful that the evidence collected could sustain the actual fines collected after stipulation. Had the insurers forced the Department to court by refusing to pay any fine, it is possible that none of the cases

would have been sustained. It might have been alleged that the Department instituted action on insufficient evidence.

Page 16

The conclusion, therefore, is not supported by the evidence. Field investigations cannot always successfully establish violations because of the manner in which these rebates are made. Tracing rebates in these cases from local to home office is not a simple matter since the actual expenses cannot always be easily characterized as rebates. The ability to initiate multiple actions simultaneously on fresh evidence can be very effective even if the case has not been fully investigated. Such cases are very rare and occur only in extraordinary situations. Certain situations require exceptional handling. Mandating uniform procedures in all instances could result in no action or ineffective action being taken.

Pages 9-10

It is believed that the seven insurers whose privilege to appoint agents under temporary licenses was suspended in 1975 obtained reductions in the period of suspension after submitting facts in mitigation or proving that our allegations were incorrect. We have not had time to make an independent search of our files, and the report has no discussion of these cases on page 15 as stated on page 10.

The report covers only the 1975 actions taken relating to the suspension of the privilege to use temporary licenses, although the auditor was asked to review the 1976 actions. The auditor was specifically asked to look at the 1976 cases because every insurer who had failed the test was automatically suspended unless it could prove that our figures were in error. No exception has been made to that procedure. It is unfair to criticize the 1975 procedures without reviewing the ones used more recently.

Page 10

The comment in the last paragraph that exceptions to normal procedures are to occur only when ". . . the Department's case is compromised after the accused has answered . . ." is unclear. It already has been stated that a licensee should always be able to establish (1) facts in mitigation not in the file or (2) errors in our pleadings.

Page 11

The statement that in the 11 cases listed in the confidential casefile reference, the Legal Division sent draft copies of proposed accusations to insurers or to former high Department officials representing these licensees is FALSE and must be known to be false to the auditor.

The auditor's claim that in one case the Chief of Legal prior to the completion of the Department's investigation negotiated and settled a case with a former Chief Deputy of the Department, as a result of which important charges were not investigated, is FALSE and must be known to the auditor to be false. That case was not referred to Legal at the Chief's request. Investigation forwarded the file for action even though additional complaints were being received. That is not unusual. Where there is a continued flow of complaints, a case may still be referred for action since to wait could mean that no action is ever taken. In such cases, pleadings are issued and may be later amended to add any additional violations uncovered in the interim. This case is a good illustration of an investigation which could still be open at this time if the bureau had waited to be sure that all complaints were investigated. In light of the evidence then available, the penalty imposed was fair.

The discussion of this case in Appendix B-2 through 5 is incomplete and not fairly stated. For instance, the reference on B-4 that the Chief of Legal declined to furnish the Department's file to the Los Angeles City Attorney ". . . because of skepticism that the City Attorney would prosecute . . ." is a surmise of the auditor's and not consistent with other known facts. The evidence available simply did not support a criminal action. The Chief of Legal met with the Los Angeles Deputy City Attorney to discuss the

case and was advised that criminal action was not contemplated but that rather a civil action to impose a fine penalty was the objective. The City Attorney has never done anything in this case, and this licensee continues to be authorized to provide insurance to the Los Angeles City employees. It was pointed out to the auditor that Insurance Code Section 12928 requires that "[w]henever the Commissioner ascertains . . ." that a violation of the Penal Code has been committed, he certify the matter to the District Attorney. The reference to Section 12930 without any comment regarding the requirements of Section 12928 is puzzling since the relationship of the two sections had been called to the auditor's attention.

The statement in the first paragraph of B-5 is false. No accusation has been rescinded on the grounds cited therein. The evidence did not support the action taken by the attorney, and moreover the insurer did pay the claim in accordance with the terms of the policy until the insured's death.

Case #4, which is discussed in B-5, et seq., was first investigated in 1969. The auditor concentrated on reviewing recent files except in a few instances. Why these few "older" cases were selected is not clear. The statement that the staff counsel who handled the case was concerned about pressure from a legislator is false in that such pressure, if exercised, does not reach staff employees.

The fifth case described on B-11 incorrectly described the violation involved.

We have been unable to identify Cases #6 and #7 and cannot comment without the opportunity to review the files.

Comments have previously been made with regard to Cases #8 and #9.

It should be noted that the auditor reviewed primarily recently handled cases, except for a few cases dating back to the 1960's; and all of these, without exception, had been handled by the now-Chief of Legal who was then a staff counsel. It would be of interest to us to know the basis for the selection of cases which were reviewed.

Pages 18-21

The auditor makes a case for the proposition that anyone convicted of a felony should have his licenses revoked under Insurance Code Section 1669 without a hearing and criticizes the Department for failing to exercise that authority. The report cites 17 cases involving felony convictions during 1975-76 which were subjected to regular disciplinary actions. The criticism and recommendations of the auditor are invalid and the course of action proposed would inevitably lead to the abuse of authority. Insurance Code Section 1669 is not mandatory but rather is

permissive and discretionary. This is obvious in light of Section 1668(m)(1), which provides for a hearing procedure for felony convictions. This statute was pointed out to the auditor. These two seemingly inconsistent laws (i.e., Section 1669 and Section 1668(m)(1)) can coexist only if read together. Section 1669 should be applied only where the facts justify it. To apply that section automatically just because of a felony conviction--without regard to the number of years which have elapsed since the conviction, the age of the licensee at the time of the conviction, the nature of the penalty (weekends in jail), etc.--would be an abuse of discretion. For instance, four of the examples cited involved former licensees. Action was taken under Section 1743 simply to make a record by default. These four no longer were transacting insurance when the cases were received by Legal. In other cases, the convictions were issued after the Department had instituted its actions; consequently, a summary order would not be possible. In still other cases, the licensees were either in jail or inactive. The report fails to indicate any review of those cases where summary action had been taken. In one of those cases, a man convicted of procuring the murder of his wife (successfully) was summarily denied a license. He appealed. The court rejected Section 1669 and directed the Commissioner to hold a hearing to determine whether the applicant had been rehabilitated. The hearing officer so found, and a license was issued. The auditor

was advised of this and other similar cases which had been mandated and where the court criticized summary actions and remanded the cases to the Commissioner for hearings. The auditor has not recognized that these court cases must be considered by the Commissioner in determining what course of action will best meet the courts' standards of fairness. At any rate, in most cases fairness requires that cases be resolved on their merits. We cannot understand the auditor's recommendation of an arbitrary course of action which flies in the face of the court decisions.

The comments that the public was unnecessarily subjected to danger of loss by allowing these 17 licensees to operate while the normal disciplinary procedures took their course are unfair and not supported by the evidence. (1) One case involved a misdemeanor conviction; (2) four cases involved former licensees; (3) in one case the accusation was issued prior to conviction; (4) several licensees were not transacting business or were in jail when action was taken; there is no evidence of undue delay.

Page 22

Procedure is well established under the "leadman system" to provide aid and assistance to investigators during the course of an investigation. The chief investigator, the supervisor and leadpersons spend much of their time answering questions, instructing as to next steps to take and in advising

investigators as to applicable Insurance Code sections. The finished product does not tend to support only those conclusions drawn by the investigator. Cases considered completed by the investigator, but which are not, are returned for additional needed investigation including recontacting witnesses and agents, where necessary, without any thought as to embarrassment as a routine procedure to assure quality of investigation and to provide experience for the investigators.

The increase in volume of cases to be investigated since 1974 has created an overload situation for the supervisors, particularly in Los Angeles, and has resulted in some weakening of compliance with established procedures but this situation is now easing.

Page 23

Investigative skills are acquired by the staff from guided, not unguided, experience. The need for formalized training has made itself apparent, however, and such a program is presently operating and evolving.

Page 24

License status is determined in every case before an assignment to investigate is opened. This is a clerical function. Before the Department had the printer in San Francisco

and Los Angeles this was done by the clerks in a handwritten note which was destroyed routinely when the investigation was closed. Printouts are now obtained which are also destroyed when the case is closed as they are no longer of value and tend to clutter the file.

Page 25

The licensee is interviewed and a statement taken as it has been shown that such a technique can be useful in having a licensee think over the seriousness of an untruthful denial.

Workload prompted a departmental policy decision to resolve matters classified as "consumer matters" by obtaining restitution for the insured. In such cases, if a violation is apparent, it will be pursued further, however. Legal Division's instructions concerning effect of obtaining restitution are not in conflict. These instructions refer to serious violations that have been evidenced--not just suggested.

Oral warnings and warning letters are given according to judgment exercised by the supervisors and the chief investigator. Preparation of a formal report for review by Legal Division in each of the approximately 5,000 cases closed annually would require extensive staff and budget augmentation.

Page 26

A departmental decision was made to destroy other than formal files after two years due to lack of filing space and the generally decreasing importance of these files as time passes.

The Bureau has a system for monitoring age of assignments through the central indexes which has been in use for many years that assures the more difficult cases are not postponed indefinitely by the investigators.

Pages 27-28

The auditor has not acknowledged that the Bureau is in the process of developing a more detailed priority system with respect to cases. Such new system will include the use of a new class of employee--the insurance assistant--to handle routine cases, thus freeing the investigators to concentrate on the more serious ones.

The specific case referred to will require review to determine if evidence of serious violations existed.

Page 28

The memo referred to does not say the backlog was unnecessary. This is a conclusion of the auditor. The backlog now existing accumulated over a period of some three years at

least partially due to an extraordinary increase in complaint matters and our inability to enlarge staff to handle them. It is extremely unlikely the persons filing these complaints felt they were unnecessary. The memo referred to the additional personnel hired in October 1976 and the hope they, when fully trained and in concert with existing staff, would be able to handle input. Reducing already existing backlog is another question.

Page 29

In referring to Insurance Code Section 775 the report fails to include the clause which allows complaints to be filed within three months of any modification of the sale agreement. The addition of Section 770.1 in 1973 has established another factor to investigate in connection with this type of insurance sales. Violations of this section are brought to our attention by other than a party to the property sale, but are investigated since departmental policy assumes such was the intent of legislature. Section 775 was added in 1951.

The investigators are instructed to obtain signed statements for many reasons including direction from Legal Division indicating that they are considered strong direct evidence and are useful, if necessary, to impeach a witness. They discourage agents from changing their stories on the witness stand. These

directions are in conflict with the statement in the report and indicate the auditor has accepted as fact the opinion of a member of the Legal Division staff without corroborating with bureau and division chiefs.

Page 30

The conclusions appear unwarranted from the information in the report. Workload pressures have forced Departmental policy to be established to lessen time spent on suspected minor violations and to concentrate efforts on serious matters and matters where strong evidence of violation exists. The chief investigator does not agree that the case volume is unnecessary. The investigators have been told repeatedly that although certain standards of case production must be maintained, the quality of the investigation is of prime importance.

It has also been pointed out that the quality of completed cases and the maintenance of standards of production go hand in hand as the efficient investigator will maintain both standards as a matter of course and will then be selected to move into the promotional positions that become available.

This report covers a period (essentially 1974 through 1976) of unusual pressure and strain on the Investigation Bureau. Requests to conduct investigations doubled but budget did not. Since we were not able to hire additional employees, more was

asked of the existing staff. The result has been that a few employees became resentful and disgruntled. The report refers frequently to workload pressures and it is apparent that this unrelieved pressure is of primary importance in establishing cause of problem areas described in the sections of this report relating to the Investigation Bureau. This pressure is just beginning to ease as a result of much effort on the part of the staff. Many of the problems described are well on their way to resolution by departmental action independent of recommendations contained in this report.

Pages 34-37

Every insurer is examined at regular (3 years) intervals. Special examinations may be scheduled if conditions warrant. The examinations are "to determine the financial condition and methods of operation of insurance carriers as well as their compliance with the California Insurance Code." (Emphasis added.) Each report of examination contains comment on treatment of policyholders. There is currently in development a "Market Conduct Examination Manual." It is anticipated that we will soon be conducting such examinations separately from financial examinations. The Examinations Division is the field staff for Policy Services Bureau.

Page 38

As we pointed out earlier (pages 5-6) it is impossible to measure complaints in the manner given in the report. For example, we have more than 400 insurers licensed to write auto liability insurance. The leading four insurers (1% of total) have more than 50 percent of the business. To say then, that 14 percent of the insurers was responsible for 81 percent of the complaints is meaningless.

There is no such thing as average business volumes.

Page 39

It is stated that nine out of the ten highest complaint rates were against life insurers. Since we do not have any further details of the auditor's list, we cannot be sure, but it is our belief he has included complaints arising out of disability insurance policies. (Refer to our comment at pages 5-6.)

Page 44

The primary concern of the Surveillance and Analysis Division is "to analyze all available information concerning the condition, operations and affairs of insurers . . . ." (Emphasis added.)

The Chief of the Consumers Affairs Division reports that the first comment of the auditor on his first visit with the Chief was, "I intend to file a highly critical report."

Pages 48-50

The recommendations for further security are reasonable, and those not requiring budget changes will be accomplished by May 1, 1977. The 1978-79 FY Budget will include a request for staffing increase to provide full nine-hour-per-day coverage of file rooms.

RESPONSES TO SPECIFIC ALLEGATIONS

Although the five specific allegations upon which this audit was initiated were germane to the results reported, only one of the specific allegations could be substantiated as indicated below:

Allegation #1

Approximately 90 percent of the complaints against life insurance salespersons involve one company.

Response

As discussed on page 38 there are important patterns of complaints against the agents of some companies, especially life insurers. We estimate that the highest complaint rate against agents of any one insurer is 11 percent of those received by the Department.

Allegation #2

Insurance investigators do not diligently pursue their work because this would jeopardize their ability to acquire positions with insurance companies upon leaving state service.

Response

We found no evidence of deliberate negligence by investigators. Generally, investigators aspire to promotion within the Department from which most investigators intend to retire.

Allegation #3

There is often a close relationship between an investigator and the industry member being investigated.

Response

We found no evidence to corroborate this.

Allegation #4

The Department is aware that some individuals, whose licenses have been revoked, continue to operate as if they were still licensed. The Department apparently takes no action.

Response

Six Department investigators indicated it was their experience to not place a high priority on investigating or disciplining individuals who transact insurance without a license. Our review of case files tended to corroborate this observation. For example, the Department has granted unrestricted licenses to some such individuals, as indicated in Appendix B.

Allegation #5

The chief of the Legal Division determines the disposition of the investigator's reports with an excessive number resulting in no action.

Response

This is an inaccurate portrayal of normal procedure. Only those investigations which the Investigation Bureau believes warrant formal legal action are brought to the Legal Division's attention. The chief of the Legal Division normally does not become involved in the disposition of reported violations until the legal staff have agreed on recommended action, based on the staff's understanding of the chief's desires. Exceptions to these procedures occur occasionally in cases of special interest to the chief.

DESCRIPTION OF SOME NOTABLE CASEFILES

The following cases exemplify some of the problems and effects discussed in the report text. These cases are only illustrative; they do not necessarily represent all disciplinary actions by the Department.

1. In 1975, investigation determined that an unlicensed out-of-state insurance agency transacted at least $296,000 in insurance premiums in California, which resulted in at least $89,800 in commissions. The agency claimed ignorance of the need to be licensed with the Department, even though the agency sold insurance in 36 other states and had a licensed California accomplice.

   The Department's Legal Division formally offered a $10,000 penalty settlement, but the accused, represented by the law firm of a former insurance commissioner, was permitted to reduce the penalty to $5,000. The casefile indicated no rationale for permitting a penalty reduction. In addition, the Legal Division cleared the accused's application for an unrestricted agency license. No restrictions were placed on the license of the California licensee accomplice.

2. In contrast to case #1, another investigation in 1975 disclosed that an out-of-state agent had attempted to sell five consumers insurance policies which had not been approved for sale in California. When the agent discovered his actions might be legally questionable, he promptly returned all documents and payments to the consumers and no insurance was ever issued.

   The Legal Division offered the accused no special deal, and pursued the case to public hearing, whereupon the accused's licenses were revoked and an application for another license was denied.

3. In 1973, a former employee of an insurance agency reported to the Department about 230 insurance policies sold by unlicensed employees of the agency. Investigation confirmed the agency's systematic, intentional practice of encouraging sales by unlicensed employees. The agency had also charged at least $37,848 in illegal monthly service fees on insurance premiums. The agency had also required membership in a union before insurance could be purchased, in violation of a warning letter issued by the chief of the Legal Division three years before (although the warning letter was not included in the file for review by the investigators).

Before the investigation had been completed, the chief of the Legal Division drafted a proposed accusation and mailed it to the accused's attorney, who is a former chief deputy commissioner. In the following five months, the chief of the Legal Division and the former chief deputy commissioner met and exchanged six drafts of proposed action. These negotiations resulted in the following:

- Deletion of factual matters questioned by the former chief deputy commissioner acting as attorney for the accused

- Addition of mitigating statements which appear to conflict with the prior Department warning

- Settlement of the case by stipulation, requiring no public access to the evidence

- Penalty of $10,000 (in lieu of a 90-day suspension), required restitution of the $37,848 illegal fees, and promises of compliance with Department-approved procedures and agent training.

Investigation also suggested the probability of systematic training of agents to misrepresent policies to insureds, but the Department did not attempt to investigate beyond the actions of selected agents, one of whose license has already been revoked for such misrepresentation. Several

other complaints of misrepresentation by other agency employees were closed "no violation" solely on the basis of the agency's promises of restitution and future compliance.

Investigators never visited the agency's Los Angeles headquarters to review its operations or files, despite recommendations of some investigators to follow up on evidence of bounced checks, which might indicate a shortage in the agency's premium trust account. In March 1977, the agency volunteered the information that it was at least several hundred thousand dollars short in its trust account.

Some aspects of the case were investigated by the Investigation Bureau's Sacramento office, but were not formally reported through normal procedures, and incomplete investigation materials were just forwarded to Legal Division attorneys.

The Los Angeles City Attorney requested that the Department furnish certified copies of its records of the case for the purpose of criminal prosecution. The chief of the Legal Division denied this request on the basis of her skepticism that the City Attorney would actually prosecute. Insurance Code Section 12930 requires the Department to provide such records for the purpose of criminal prosecutions.

Since the settlement of the case, the Department received a number of complaints indicating violations of the settlement agreement and further misrepresentations in insurance sales. The Investigation Bureau documented some of the violations, but no action was taken. In October 1976, a Legal Division attorney issued a formal accusation on charges of fraud, forgery, and unlicensed sale to one consumer. The chief of the Legal Division rescinded the accusation, supposedly because the insurer might be willing to pay a claim based on the agent's sales misrepresentations rather than on the actual policy. No further action has been taken against the agency or its agents.

4. Examples #4 (a) through (s) represent the entire file of public complaints and disciplinary actions against one insurance agent through 1976. All investigations and legal actions were approved through normal supervisory review. A total of 11 investigators handled one or more of these cases out of the San Francisco office. Eight of these investigators are still in the Bureau.

   a. The complaint file was opened in 1969, when investigation of a complaint indicated that the accused agent had illegally diverted at least twenty clients from her employer to another agency. After leaving that employment, the agent sold insurance without proper

license. Once the Department began investigating the complaint by her former employer, she applied for an agent's license.

In the opinion of the staff attorney (now chief of the Legal Division) to whom the violations were referred, the accused's license application would have to be denied unless the accused at least admitted guilt. The attorney was also concerned about pressure from a legislator's office to clear the license application. The attorney later changed her mind, and in May 1969 the accused was issued a restricted license without having to admit guilt to any violations.

b. In 1970 the Department reprimanded the licensee for selling insurance outside her license between May and August 1969. The Department accepted as mitigation a supposed oral agreement between the licensee and an insurer effective July 1969.

c. In 1970, the Investigation Bureau received a complaint of the licensee selling outside her license through another licensee. The investigator (now chief investigator) closed the case informally because the Legal Division was granting her a license to cover the kind of activity not covered by her previous license.

d) In 1973, the Investigation Bureau received a complaint of the licensee selling outside her license. The case was closed informally despite the licensee's admission to the allegation.

e) In 1973, Investigation Bureau received a complaint of the licensee's failure to return a premium. The case was closed informally on the basis of the licensee's denials, despite the investigator's acknowledgment of no evidence to support her statement.

f) In 1973, the Investigation Bureau received a complaint of the licensee selling an insured the wrong policy. The case was closed "no violation" on the basis of the licensee's secretary's statements without seeking corroboration in the licensee's files.

g) In 1974, the Investigation Bureau received a complaint of the licensee's unjustified cancellation of an insured's policy. The case was closed "no violation" on the basis of the licensee's description of events without seeking any corroboration.

h) In 1974, an insurance company informed the Department that the licensee might have a shortage in her premium

trust account. The Investigation Bureau did not audit her trust account, but did warn her not to use unauthorized business titles.

i. One month after the warning letter was sent in case 4(h) the same investigator received correspondence from the licensee showing continued use of the unauthorized business titles. The investigator took no action on the violation of his warning letter. (Licensee had yet to comply with this technical matter as of March 1977.)

j. In 1974, the Investigation Bureau received a complaint that the licensee had incorrectly advised the insured of the necessity for special insurance coverage. The case was closed "no violation" after the licensee blamed the insurance company for giving her bad advice. The case file did not include any substantiation for the licensee's statement, and no investigation was made of potential misrepresentation by the insurance company.

k. In 1974, the Investigation Bureau received a complaint of the licensee's failure to notify insured of policy cancellation until after an insurance claim had been filed. The case was closed "no violation" on the basis of the licensee's lack of records. (Insurance Code

Section 1747 permits the Department to seek revocation if a licensee's records are not brought up to standard within sixty days after a formal Department warning.)

l. In 1975, the Investigation Bureau received a complaint of the licensee selling a policy from a company the insurer did not want. The case was closed informally despite the licensee's admission of no records, and documentation from the insurer of a possible violation by the licensee.

m. In 1975, the Investigation Bureau received a complaint of the licensee selling a consumer a policy he did not desire. The case was closed "no violation" on the basis of the licensee's explanation despite a lack of records to document her explanation.

n. In 1975, the Investigation Bureau received a complaint of the licensee's failure to refund an insured's premium down payment. The case was closed informally despite the licensee's lack of records to document her explanation.

o. In 1975, the Investigation Bureau received a complaint of the licensee accepting a premium for insurance but not securing a policy or returning the premium to the

consumer until after the consumer filed an insurance claim. The case was closed "no violation" despite the licensee's lack of records.

p. In 1975, the Investigation Bureau received a complaint alleging that the licensee sold a consumer the wrong type of policy. There is no record in the file of any investigation of this complaint.

q. In 1975, the licensee complained to the Investigation Bureau that an insurer was replacing her as broker of record on some policies. The case was closed with a warning to the licensee to remit any premiums collected on such business. However, the file includes no record of inquiry to the insurer regarding its justification for replacing the licensee as broker of record.

r. In 1976, the Investigation Bureau received a complaint of the licensee overcharging for the insured's coverage. The case was closed informally after the insured was given a refund. The investigator reported that both the licensee and the insurer had knowingly misrepresented the policy coverage, but no action was deemed necessary because neither was selling that type of policy anymore.

s. In 1976, the Investigation Bureau received a complaint from the licensee that an insurer would not accept her

business unless she placed it through other agents. This case was not even opened, let alone investigated to determine why the insurer refused the licensee's business or whether the licensee was illegally selling through other agents.

5. In 1974, an insurance company employee reported to the Department that the company had a scheme for fraudulently increasing the apparent amount of its financial reserves on workmen's compensation insurance. Investigation by the Investigation Bureau verified that the insurer's reserves were artificially inflated by 29 percent, or $8.5 million. This simultaneously reduced dividends payable to policy holders by $1.5 million. False reporting of reserves to the California Inspection Rating Bureau (CIRB) affected the setting of workmen's compensation insurance rates.

   The chief of the Legal Division drafted a proposed accusation charging the company with willful submission of false information to the CIRB. However, the insurer was permitted to review and negotiate drafts of proposed actions by the Department, which resulted in the Legal Division 1) dropping the charge of willful violation, 2) eliminating a proposed $10,000 penalty, 3) requiring no admission of any violations, and 4) ordering the company to eliminate its artificial reserves scheme.

6. In 1974, the Investigation Bureau received a complaint alleging misrepresentation and illegal rebates by an insurance agency. The case was closed "no violation" 21 months later on the basis of the accused's denials and a question whether the accused had been licensed by the Department at the time of the allegedly misrepresented insurance sale.

7. a. In 1964, a special examination of an insurer by the Department's examiners disclosed an insurer's failure to refund premiums to insureds as appropriate. The insurer promised corrective action in 1965.

   b. In 1966, a regular examination of the insurer disclosed continued failure to refund premiums. The insurer's parent company promised corrective action.

   c. In 1968, the Department made another special examination as a result of persistent rates of policyholder complaints of insurer failure to return premiums. The chief deputy commissioner said that corroboration of the complaints should lead to action against the company's license. However, after the special examination corroborated the continuing problem, the staff attorney (now chief of the Legal Division) to which the case was assigned decided that only a warning letter was necessary because of the company's promises of future compliance.

8. Background: The Insurance Code authorizes the Department to suspend an insurer's privilege to appoint temporary agents if less than one-third of the appointees pass the Department's license examination in a given year. The Code requires the companies to submit by August 15 of the following year their annual reports of such rates of exam passage.

Case History:

a. In 1969, only 20 percent of a life insurer's appointed temporary agents passed the exam. In January 1971, the Legal Division initiated action against the insurer's appointment privilege. In June 1971, the Legal Division suspended the insurer's privilege for 60 days. The Legal Division said it was lenient because it had taken so long to act and because the insurer promised to improve the training of its agents.

b. In 1973, only 14 percent of this insurer's appointees passed the exam. In October 1974, the Legal Division formally offered the company a 365 day suspension of appointment privileges. The insurer signed the offer, but substituted 180 days as the suspension period. In January 1975, the chief of the Legal Division signed an order specifying the reduced penalty. There is no evidence in the case file of any rationale for the penalty reduction.

c. In 1974, only 16 percent of the company's appointees passed the license exam. In September 1975, the Legal Division suspended the company's appointment privilege for another 180 days.

d. In December 1975, the Investigation Bureau disclosed that the company had allowed unlicensed agents to sell insurance in violation of promises made to the Department in 1973 and the suspension of appointment privileges in 1975. The Investigation Bureau closed the case prematurely upon advice from the Legal Division that no action would be taken against the insurer even if proof of violations were found. The reason given was that the company had come into compliance.

9. In 1969, only 30 percent of another company's appointees passed the license exam. In January 1971, the Legal Division formally offered a 30 day suspension penalty. The company did not return tne signed offer until July 1971, despite written instructions on such offers that they expire after 15 days, whereupon the Department takes the matter to public hearing. In July, the Legal Division accepted the signed offer and the period of appointment suspension was ordered to begin in August.

10. An examiners' report in December 1974 indicated that another insurer received numerous complaints against its agents for misrepresenting policies to insureds. Subsequent analyses by the Surveillance and Analysis Division and the Policy Services Bureau indicated that the insurer's procedures appeared to be the source of the problem. In May 1976, a Surveillance and Analysis Division analyst, and in October 1976 the Division's legal counsel recommended to the division chief that legal action be taken against the insurer. There is no record of the chief referring the case for further action.

    Simultaneously, the Investigation Bureau's investigation of the insurer's agents revealed proof of systematic illegal procedures of the insurer. However, in February 1977 the chief investigator decided no legal action was warranted because a case had not been developed against a specific agent.

11. In 1969, the examiners reported that the directors of a life insurer had conflicts of interest with their sales representatives, in violation of Insurance Code Section 10434. Rather than revoke the insurer's license as required by Section 10435 of the Code, the Legal Division permitted the insurer to have the directors resign.

In a memo to the commissioner from the chief of the Legal Division, the Department's reasoning became clear for not following the Code's mandate in such cases. She was concerned that Section 10435 was unnecessarily punitive, and that it was unfair since it only applied to life insurers, while other insurers could have such conflicts of interest without reproach. However, the Department's legislative representative told us the Department has taken no action to seek amendment of Section 10435.

In her memo on the subject, the chief of the Legal Division stated that in the particular case noted, "I will concede that corrective action was overdue but I do not understand why we proceeded with such alacrity against (this insurer) while allowing many other carriers to violate the provisions of this section."

12. In June 1968, the Department made a special examination of an insurer to investigate a pattern of complaints received by the Policy Services Bureau. The special examination verified the insurer's practice of unfair treatment of policyholders, which resulted in unnecessary delay and unreasonable refusal to pay insurance claims. In September 1968, the Legal Division sent a formal accusation to the accused but the Department delayed holding a hearing to "listen to the plaints" of the insurer. No action was taken. A subsequent examination

of the insurer in 1969 produced no mitigating evidence. No action was taken. Finally, in April 1975, the Legal Division closed the case because of its age.

DEPARTMENT'S ASSERTION OF FALSE REPORT STATEMENTS

The Department's response contains several assertions that portions of our report are false. The following items relate these assertions to documents in this appendix which refute these assertions.

- The Department's response page DI-8 states as follows. "The statement that in the 11 cases listed in the confidential casefile reference, the Legal Division sent draft copies of proposed accusations to insurers or to former high Department officials representing these licensees is FALSE and must be known to be false to the auditor." Page C-2 is a letter to the former Chief Deputy Insurance Commissioner transmitting "a rough draft of an Accusation" by the current Chief of the Legal Division. Page C-3 is a letter to the same law firm transmitting a draft press release on another case. These are but two examples.

- The Department's response page DI-9 states as follows. "The discussion of this case in Appendix B-2 through 5 is incomplete and not fairly stated. For instance, the reference on B-4 that the Chief of Legal declined to furnish the Department's file to the Los Angeles City Attorney'...because of skepticism that the City Attorney would prosecute...'is a surmise of the auditor's and not consistent with other known facts." Page C-4 is a letter from the Los Angeles City Attorney which has a hand written note by a Departmental attorney describing a meeting of the Chief of the Legal Division with the City Attorney's office. This note states "AK-7-11-75 met with representatives from Pine's office (City Attorney) and declined to give out info (sic) because no assurances that criminal action would be taken."

- Page DI-10 of the Department's response states as follows. "The statement that the staff counsel who handled the case was concerned about pressure from a legislator is false in that such pressure, if exercised, does not reach staff employees." Page C-5 is a current memo concerning the handling of matters referred by the Legislature or the Governor's office with the final paragraphs stating staff is to be provided with a copy of this memorandum. Page C-6 is the memo describing the contact by the Legislator's office.

July 11, 1975

Mr. Harry O. Miller
Attorney at Law
9100 Wilshire Blvd.
Suite 955
Beverly Hills, CA 90212

Re:

Dear Mr. Miller:

Attached is a rough draft of an Accusation we propose to issue against the licenses of
It is not complete, as we anticipate adding one or more charges following completion of our investigation of the Los Angeles employees' complaints sometime next week.

I shall be in Los Angeles on the 21st and will be happy to discuss this matter further with you at that time.

Very truly yours,

WESLEY J. KINDER
Insurance Commissioner

By

ANGELE KHACHADOUR
Chief Counsel

AK:hcr
Attach.

November 6, 1975

Law Offices of Maddox
and Miller
Suite 955 Wilshire-Doheny
Plaza-West Tower
9100 Wilshire Boulevard
Beverly Hills, California 90212

ATTENTION: Harry O. Miller

SUBJECT: Insurance Company:
Issuance of Unauthorized Policy Forms

Gentlemen:

I am informed that the policy documents which are to be used to reform the improperly issued policies to comply with this Department's Ruling No. 183 have been authorized. As I have noted previously, this Department is agreeable to the terms of the stipulation and agreement set forth in your letter of July 17, 1975. Although you have submitted two photocopies of that letter, signed by a vice president of Globe Life, we must request that you submit an original document signed by you and an officer of . We would also like a written commitment from Company that it will abide by the terms of the stipulation and agreement insofar as they may affect the administration of the policy forms involved.

Enclosed is a draft of the press release which we propose to issue upon our signing of the stipulation and agreement. Any comments you may wish to make about it will be considered when we prepare the final release.

Very truly yours,

WESLEY J. KINDER
Insurance Commissioner

By
PETER GROOM
Senior Counsel
(415) 557-3713

PG:kmd

Enclosure

AK - 7-11-75 - met with representatives from Pines office and declined to give out info because 240 assurances that criminal action would be taken

OFFICE OF
CITY ATTORNEY
CITY HALL EAST
LOS ANGELES, CALIFORNIA 90012

RECEIVED
JUL 3 1975
DEPARTMENT OF INSURANCE
SAN FRANCISCO

BURT PINES
CITY ATTORNEY

June 30, 1975

Insurance Commissioner
Department of Insurance
State of California
1407 Market Street
San Francisco, California 94103

Attention: Mr. Philip Hinderberger

Dear Sir:

In our official capacity and with regard to matters touching the jurisdiction of this office, for the purpose of evidence in the possible prosecution of alleged misdemeanor conduct, we hereby request that the Commissioner furnish to the Los Angeles City Attorney, without cost to the city, certified copies of any paper or records of the Office of the Commissioner thereof in the matter of   , and related entities.

The scope of our inquiry for possible criminal prosecution and for filing of a civil complaint seeking a judgment with civil penalties is all activities arising out of or relating to transactions with the County of Los Angeles.

Thank you for your prompt attention to this matter.

Very truly yours,

BURT PINES,
City Attorney

Max Factor

MAX FACTOR, Director
Consumer Protection Section

MF:hw

State of California

Memorandum

To : Mr. R. P. Donnachie
Mr. J. F. Petkovich
Mr. A. Ruchliewicz
Mr. A. L. Selna

Date: October 22, 1975

From : Department of Insurance - Edward L. Middelton
1407 Market St., San Francisco 94103

Subject: Investigation Matters Referred From Legislators

I am having a continuing problem resulting from the fact that previous memoranda on this subject are not being followed by the investigators.

Matters referred to us for investigation by Legislators or the Governor's office are to receive priority. If the case is not resolved within 30 days of receipt, a status report must be sent to Leo Hirsch in San Francisco. A follow up report is to be sent every 30 days thereafter in which the case is not completed.

Please provide your staff with a copy of this memorandum.

EDWARD L. MIDDELTON

ELM:bk

7. It was the understanding of the undersigned that Mr. had offered to sell his business to Mrs. for a sum far below that which he had had to pay for it. Mr. agreed that any stipulation by Mrs. would have to be made conditional to her reaching an agreement with her former employer for the purchase of the business and further that Mr. would have to forego court action for damages.

8. On April 3 or 4, a gentlemen by the name of claiming to be from the office of Senator called Mr. and asked him why we were forcing this woman to confess to something that she had not done and which might subject her to a law suit from her employer. Obviously, Mrs. had been contacted by her attorney and had on that same day reported a distorted version of my conversation with Mr. to the Senator's office.

9. Mr. called me on the 3rd or 4th and demanded to see a copy of the complaint filed by Mr. . I politely advised him that until formal action was taken against Mrs. that complaint remains confidential.

10. This morning Mr. was advised that unless this matter can be settled by stipulations, formal pleadings would be prepared by me toward the end of the current month.

Angele Khachadour

ANGELE KHACHADOUR

AK:kn

MDF:cjf

SELECTED CORRESPONDENCE REGARDING DIFFICULTY IN ACQUIRING DEPARTMENTAL ACTION

The following chronological correspondence demonstrates an example of Department's inertia in responding to reports of illegal licensee conduct.

April 16, 1975

Commissioner Wesley J. Kinder
State of California
Department of Insurance
1407 Market Street
San Francisco, California

Dear Commissioner Kinder:

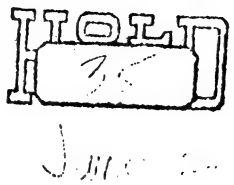
Be advised that the Business Practices Committee of this association has received a written complaint from P making certain allegations against Mr. W of The Prudential Insurance Company of America. The allegations appear to represent the possible commission of public offenses and possible securities irregularities on the part of Mr. W .

Mr. P , whose address is , Palo Alto, California 94301 (Res: , Bus:) has requested the Business Practices Committee of this association (which comes within my jurisdiction as its Vice President) to forward this complaint in writing to your office so that it may be immediately investigated. It is my understanding from the Department of Insurance that Mr. W is also under investigation with regard to other matters that may be quite similar, if not identical, to the pattern established in the P case.

We are enclosing for your perusal and assistance photocopies of information (original) contained in our file which will be available for your perusal.

In that several agencies may be involved, (the NASD, the San Jose Police Department and the Department of Insurance) perhaps you might wish to contact me or Mr. Del Byler who is the Chairman of the Business Practices Committee (286-2100) and arrange for a meeting when all interested parties could be present to go over the evidence and discuss the case. At that meeting I'm sure that it would be possible to have Mr. P present as well.

May 19, 1976



Governor Jerry Brown
California State Capitol
10th at L North
Sacramento, CA 95814

Dear Governor Brown:

Please find enclosed copies of news articles regarding criminal sanction and actions being taken against persons commiting public offences in the county of Santa Clara. We have attempted on several occasions to receive assistance of the insurance commissioner regarding the commission of crimes within our jurisdiction, but to no avail. I have personally, as chairman of a select committee on white collar crime and business fraud, written to Commissioner Kinder; he has not answered any of my several letters, nor has he responded to any of my phone calls. The only other person who can help at this point is your office. We have reason to believe that crimes being committed by persons in California are being covered up by the insurance commissioner and/or his staff. Even though I am speaking for myself as an individual, I think that the other members of the committee would agree that the covering-up of crimes and the refusal to investigate and prosecute criminals, be if for personal gain or other reasons, is something that we, as Americans, have had quite enough of.

I know you have been very busy lately, running for President of the United States, however, would you please see that this matter receives the attention that it deserves. I will not wish to speak with someone who is at a level in state government below that of Commissioner Kinder. You have recently expressed your desire to clean up government; now is your opportunity to prove you mean what you say to at least one of your constituents.

Most sincerely,

Lee M. Koster
President

LMK/pb

Enclosure

June 21, 1976

Governor Edmund G. Brown, Jr.
State Capitol
10th at L North
Sacramento, CA 95814

Dear Governor Brown:

For some time I have tried (in various ways) to get the attention of the Executive Branch about conditions that have been either experienced personally by me or reported directly to me by members of the Insurance Commissioner's staff. I feel that I have now succeeded. Perhaps, rather than referring this matter to the very agency that is in question (it's sort of like referring the Watergate Scandal to the White House for "investigation") as you did previously, you may wish to refer it to a more "objective" agency. Find my letter to Commissioner Kinder as well as the two copies of correspondence. You've got the ball.

Very truly yours,

Lee M. Koster

LMK/pb

State of California
GOVERNOR'S OFFICE
SACRAMENTO 95814

EDMUND G. BROWN JR.
GOVERNOR

916/445-6131

July 8, 1976

Mr. Lee M. Koster, President
Planned Estate Investment
Service, Inc.
1655 Willow Street, Suite I
San Jose, California 95125

Dear Mr. Koster:

Thank you for your letter to Governor Brown.

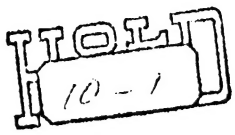
I have contacted the office of the Insurance Commissioner and am informed that an appointment for you to meet with Commissioner Kinder in his San Francisco Office will be arranged at your convenience. I have requested the Commissioner to report to me the substance of your discussion.

Your charges against Commissioner Kinder and his staff are very serious. If you have proof of your accusations that crimes are being covered up by public employees, I recommend that you forward the evidence immediately to this office or report it to the appropriate District Attorney's Office for prosecution.

We appreciate your concern.

Sincerely,

David H. Fox
Cabinet Secretary



August 19, 1976

Mr. David H. Fox
Cabinet Secretary
State of California
Governor's Office
Sacramento, CA 95814

Dear Mr. Fox:

Thank you for your letter of July 8. This is to advise you that nobody from the Commissioner's office has made an attempt to arrange an appointment at my convenience. Furthermore, you should be advised, that all of my telephone as well as my written communications attempting to arrange such an appointment with Commissioner Kinder have been met with an absolute silence. Mr. Kinder does not answer either his phone calls or his correspondence. Directing your attention to the second paragraph of your letter, I have already sent you a rather documented report with respect to specific instances, periods of time, names of companies, dollar amounts, and possible individuals involved. If you think that I am going to do an investigation into the Insurance Commissioner's office and completely work up your entire case for you, then you are quite mistaken, sir. I am a citizen of the State of California and rely on the executive branch of the government to investigate the Department of Insurance. I do not feel it is my job to do so. The very little that I have done to date, which amounts to nothing more than receiving information from confidential informants on the Insurance Commissioner's staff, has resulted in an incredible amount of pressure being brought to bear upon me from all sorts of interesting places. Apparently the threat of the Chief Legal Counsel of the Insurance Commissioner, that such pressure would be brought to bear, was made with calculated and considerable sincerity.

I am an American citizen and I'm quite proud of my heritage. And, I feel as a citizen I have not only the right but the duty to speak out when a member of the California government tells me that irregularities are occurring within. I have merely transmitted to you already the information that I have. Your suggestion to me in your letter of July 8 that I have not given you anything to work with can lead me only to believe that the Governor's office as well would wish to cover up this entire matter.

As far as forwarding any more information to the District Attorney's office, I at this point, am not too sure of who is in bed with who, and for that reason, I am sending nothing new to anyone new. If you do appreciate my concern as you state in your letter, then why don't you do something about it and investigate the material that I have already given you. My personal assessment of the situation as it regards the Governor's office at this point, is that Governor Brown doesn't really give a darn one way or the other. I am quite certain that the Government of California is quite capable of covering up any wrong doing and as a result of recent developments it would be unhealthy if I were to continue. As I have said in the past, I will answer questions, but I am not going to pursue this matter any further, primarily for considerations of my own personal safety. Congratulations on having won, but you and your good governor should be ashamed of yourselves.

Sincerely yours,

DICTATED BY MR. KOSTER
(SIGNED IN HIS ABSENCE)
Lee M. Koster
President

LMK/pb

P.S. If Commissioner Kinder would like to meet, you may advise him that he may call our office for an appointment - I wouldn't go to his office on a bet.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps